EDITORIAL

Practice of Physical Restraint and Seclusion in India: A Call for Consensus

The practice of seclusion and/or restraint of a psychiatric patient for therapeutic purposes, though carried out infrequently, seem to be widely prevalent in India (Khastgir et al., 2003, in press). This revelation has led to a series of intense deliberations and peer-review in two workshops during the annual national conferences of the Indian Psychiatric Society in two consecutive years in Pune and Kolkata. One would have to agree that detaining or restraining a patient against his/her will and consent, involves a wide range of considerations.

These considerations are necessarily multidimensional. The axes of moral, ethical, professional and legal are not invariably convergent. There may not be any parallelism between what is viewed as good/desirable for the patient from a clinician's point of view and the dictates of legal framework within which the psychiatrists carry out their practice. These are the days of judicial activism, and within its limits, the lessons learnt from Tejpur and Erwadi, might cause some advances in the way we practice our craft. The currently available Mental Health Act (1987), is unclear, at best, to determine if restraint prescribed and enforced by the doctor is entirely legal, even though the same could be entirely ethical and moral and even, professionally sound step.

The deliberations of the workshops have been undeniably stormy but in the end, some consensus appears to have been achieved. These were conducted because of the necessities of the moment, which is well appreciated and the findings are bound to make room for a wider call for consensus about the way seclusion and restraint are practiced in this country. As always, it is natural to have a set of radical and divergent notions about these modalities of treatment. While some would say that all patients are, can and must be managed without resorting to isolating them or tying them up, there are others who feel that in the larger interest of the patients' welfare, during the course of clinical work, restraint in some form, on a few occasions, is inevitable!

In an era of psychodynamic sophistication and pharmacologic advances, discussing physical control of the mentally ill may seem to be distinctly anachronistic. To some the discussion may suggest regression to the methods of less enlightened era, particularly after the recent public interest litigations. Despite such reservations, physical restraint and seclusion still remains one of the important treatment techniques in the management of violent, disruptive and even uncooperative patients. In some form or other physical restraint and seclusion is still used in most of the clinical settings.

Physical restraint and seclusion have been used since time immemorial not only by mental health professionals but also by other health professionals, sometime or other, to prevent the serious disruption of treatment programme, caused by the patient. Paradoxically, the architect of humane reform, Pinel himself was among the first to describe the basic principles of restraint and seclusion. He, however, stressed the importance of safety and patients' rights in these types of interventions. Since then there have been a number of reviews, observations, case studies and even policy guidelines, particularly in the last three decades. But have we increased our knowledge regarding the importance of restraint and seclusion, their indications, contraindications, risks and benefits among other important issues?

The literature on this subject is varied. Fitzgerald and Long (1973) and Gutheil (1978), among others, emphasized the importance of restraint and seclusion in treating patients. They point out that the appropriate use of these treatments led to positive behavioural outcome. On the other hand, Irwin (1987) and Outlaw and Lowery (1992) stated that these were methods to punish those who disturbed and/or disrupted the ward discipline. Guirguis (1978) had maintained that mechanical restraints belong in the museums, and are still used only because of staff ignorance. Ferrier, while chairing the first workshop in Pune ANCIPS, opined that the issue in India was largely one of under-resourcing, thus underscoring the need for appropriate training of mental health professionals, particularly those manning the acute care or emergency psychiatric facilities.

Further criticisms of this form of treatment have come from the human rights activists and through the development of consumer protection acts. In the USA, National Institute of Mental Health (NIMH) held a series of meetings between 1990 to 1992 on the alternatives of involuntary treatment. In one of these reports, it has been mentioned that some patients found their experience of physical restraint as similar to the experience of rape or physical abuse.

There have been a number indications and contraindications proposed by different authors for the use of physical restraint and seclusion. The American task force report on restraint and seclusion (Tardiff, 1984) has also described several indications and contraindications. Recognizing the inherent risk and potential for intentional and unintentional abuse and neglect, APA task force on restraint and seclusion has developed implementation guidelines for physical restraint and seclusion, which include indications, contraindications, authorization, initiation, duration, nature of seclusion room or restraints, observations, care of the patient, release and documentation.

In India, till date, there are no studies on the effects of restraint and seclusion on the patients and the family members. However, with the growth of consumer movements, we can expect more and more literature reflecting diverse viewpoints regarding the use of restraint and seclusion. There was however a consensus in these workshops, and also in the preceding study, that there was a need to prescribe, rather infrequently, some forms of physical restraints and seclusion to manage some of our patients, so there was a definite and

urgent need for guidelines. Is it then a good time to deliberate on, evolve and issue a consensus statement on this really vital issue!

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